

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Founders Plaza Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 721 S Hwy 78 Wylie, TX 75098	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the medications for four (Resident #1, Resident #2, and Resident #3) of fifteen residents were provided a safe and secured storage with limited access.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident 1's bottle of One-A-Day multivitamins was not left on top of the resident's right side table on 10/22/2024. The facility failed to ensure Resident 2's Benadryl cream was not left on top of the resident's left side table on 10/22/2024. The facility failed to ensure Resident 3's zinc oxide was not left on top of the resident's left side table on 10/22/2024. <p>These failures could place the residents at risk of not receiving medications, accidental overdose, or misuse of medications.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Resident #1's Face Sheet, dated 10/22/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #1 was diagnosed with dementia (term used to describe a group of symptoms affecting memory and thinking) with unspecified severity. <p>Review of Resident #1's Comprehensive MDS Assessment, dated 08/01/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment also indicated the resident had medically complex conditions.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 10/18/2024, reflected the resident was at risk of memory problem related to dementia and one of the approaches was minimize distractions.</p> <p>Review of Resident #1's Physician Orders on 10/22/2024 reflected no order for multivitamins.</p> <p>Review of Resident #1's Baseline Care Plan, dated 02/12/2024, reflected the resident may not self-administer medications.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's List of Assessments on 10/22/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage his own medications.</p> <p>Observation and interview with Resident #1 on 10/22/2024 at 1:47 PM revealed the resident was in her bed, awake. It was noted that the resident had a container of One-A-Day multivitamins on her right side table. The resident said she has not taken her vitamins for almost two weeks. She opened the container of multivitamins and it was noted that the container was halfway full.</p> <p>2. Review of Resident #2's Face Sheet, dated 10/22/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 was diagnosed with dementia.</p> <p>Review of Resident #2's Comprehensive MDS Assessment, dated 09/20/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 01. Resident #2's Comprehensive MDS Assessment indicated the resident had dementia.</p> <p>Review of Resident #2's Comprehensive Care Plan on 08/29/2024 reflected the resident was at risk of memory problem related to dementia and one of the approaches was minimize distractions. The resident did not have a care plan for self-medication.</p> <p>Review of Resident #2's Physician Orders on 10/22/2024 reflected the resident did not have an order for Benadryl cream.</p> <p>Review of Resident #2's List of Assessments on 10/22/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage his own medications.</p> <p>Observation and interview with Resident #2 on 10/22/2024 at 1:57 PM revealed Resident #2 was in her bed, awake. It was observed that there was a tube of Benadryl cream on the resident's right side table. When asked if she was using the Benadryl, the resident did not answer.</p> <p>Observation and interview with LVN A on 10/22/2024 at 2:12 PM, LVN A stated she did not notice that there was a bottle of multivitamin on Resident #1' side table and was not aware how long the medication had been sitting on the table. LVN A entered Resident #1's room and saw the container of multivitamins at the side table. She told Resident #1 that she would keep the multivitamins first and would check if there was an order for her multivitamins. The resident told LVN A that she have not taken her multivitamins for almost two weeks. LVN A then went inside Resident #2's room and saw the tube of Benadryl on the resident's side table. She told the resident that she should keep the Benadryl first and would check if there was an order for Benadryl. LVN A said there should be no medications inside the residents' rooms or anywhere accessible to other residents and visitors. She said it could be accidentally ingested and children could mistake it for candies. She said she would look at the rooms of other residents and make sure there were no medications were inside the rooms. She said, also confused residents might overdose if they can not remember if they had already taken the medication or not.</p> <p>3. Review of Resident #3's Face Sheet, dated 10/22/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #3 was diagnosed Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's Comprehensive MDS Assessment, dated 09/06/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment also indicated the resident was always incontinent for bladder and bowel.</p> <p>Review of Resident #3s Comprehensive Care Plan, dated 09/26/2024, reflected the resident had episodes of bladder and bowel incontinence and one of the approaches was to provide incontinent care after each incontinent episodes.</p> <p>Review of Resident #3's Physician Order dated 06/24/2022, reflected Barrier cream to perineum after each incontinent episode every shift.</p> <p>Observation and interview with Resident #3 on 10/22/2024 at 10:28 AM revealed the resident was in her bed, awake. A container of zinc oxide was observed on top of the resident's left side table. She said the ointment was used every time the staff cleaned her and changed her brief.</p> <p>In an interview with CNA B on 10/22/2024 at 10:46 AM, CNA B stated the zinc oxide should not be left on the side table because the resident might be confused and mistakenly swallowed the cream. She said they might be harmed if the ointment was ingested. CNA B went inside Resident #3's room and put the zinc oxide inside the resident's drawer. She said she would check the other rooms and made sure the skin protection ointment was inside the drawers and with limited access to other residents and visitors.</p> <p>In an interview with the DON on 10/22/2024 at 3:24 AM, the DON stated all the medications should be inside the medication carts. She said they should check the rooms during their rounds if there were medications inside the rooms of the residents of which they were not aware. She said if a family member was the one bringing the medications, the family member should be educated of the harm if the medications were accessible to others. She said the multivitamins and the Benadryl should be inside the cart. She said the zinc oxide, used during incontinent care, should be placed inside the drawer of the side tables after using it. She said if the resident or a visitor ingested it, there could be adverse reactions especially if somebody who accidentally ingested the medications were allergic to the medications. A child who accidentally swallowed the medication could choke from it. She said the expectation was no medications would be inside the room and the ointment used for incontinent care be placed inside the drawer to secure it. She said another expectation was for the staff to be mindful and observant that if they see any medication, they should take appropriate actions to prevent adverse outcomes such as choking and overdose. She said they would collaborate with the physician if the medications were really needed, make and an order for it, and place them in the cart for the nurses' or aide administer it. She said she would do an in-service about medication administration and making sure no medications were inside the room.</p> <p>In an interview with the Administrator on 10/22/2024 at 3:45 AM, the Administrator stated all medications should be in the cart and not inside the residents' room. He said the ointment used for incontinent care should be in the drawer or somewhere secured. He said if there were medications inside the residents' rooms, it could result to accidental ingestion and overdose, especially if nobody was monitoring it. He said the residents could also choke if they were self-medicating and nobody would know. He said the expectation was for the staff to make sure no medications were inside the room or where easily accessible to other residents and visitors. He said he would coordinate with the DON so the issue would not happen again.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy, MEDICATION MANAGEMENT PROGRAM Nursing Policies and Procedures revised May, 05, 2023 revealed POLICY:</p> <p>The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents . SCOPE AND ROLES . 4. Prescribed medications and supplements are only administered by qualified, certified, or licensed personnel.</p>